Influence of physicians’ life stances on attitudes to end-of-life decisions and actual end-of-life decision-making in six countries

J Cohen,1 J van Delden,3 F Mortier,2 R Löfmark,4 M Norup,5 C Cartwright,6 K Faist,7 C Canova,8 B Onwuteaka-Philipsen,9 J Bilsen,1,2 on behalf of the Eureld Consortium

ABSTRACT

Aim: To examine how physicians’ life stances affect their attitudes to end-of-life decisions and their actual end-of-life decision-making.

Methods: Practising physicians from various specialties involved in the care of dying patients in Belgium, Denmark, The Netherlands, Sweden, Switzerland and Australia received structured questionnaires on end-of-life care, which included questions about their life stance. Response rates ranged from 53% in Australia to 68% in Denmark. General attitudes, intended behaviour with respect to two hypothetical patients, and actual behaviour were compared between all large life-stance groups in each country.

Results: Only small differences in life stance were found in all countries in general attitudes and intended and actual behaviour with regard to various end-of-life decisions. However, with regard to the administration of drugs explicitly intended to hasten the patient’s death (PAD), physicians with specific religious affiliations had significantly less accepting attitudes, and less willingness to perform it, than non-religious physicians. They had also actually performed PAD less often. However, in most countries, both Catholics (up to 15.7% in The Netherlands) and Protestants (up to 20.4% in The Netherlands) reported ever having made such a decision.

Discussion: The results suggest that religious teachings influence to some extent end-of-life decision-making, but are certainly not blankly accepted by physicians, especially when dealing with real patients and circumstances. Physicians seem to embrace religious belief in a non-imperative way, allowing adaptation to particular situations.

Physicians’ attitudes to life and death appear to influence their end-of-life decision-making.1 It is important therefore to both assess their attitudes2 and understand exactly how these are related to end-of-life decision-making. Research has generally corroborated that (stronger) theistic religious beliefs are associated with lower acceptance of various end-of-life decisions (ELDs), particularly euthanasia.3-5 Often this is explained by the traditional viewpoints of Judaism, Catholicism, Protestantism and Islam (or their religious authorities) regarding end-of-life issues, extensively described in the bioethical literature.6-10 However, as these traditional religious doctrines are commonly balanced by considerations of due care and general sentiments of humanity and compassion, which come into play in actually dealing with patients, there is some dispute over the decisiveness of statements of doctrine for physicians’ actual decision-making.10 A specific research question of this study is therefore: are viewpoints from different life stances on different kinds of ELDs, as illustrated in the recent Lancet series,11 16 17 also translated into attitudes and actual practices of the physicians who adhere to these life stances? We will examine the effect of life stance on physicians’

- general attitudes to different ELDs: non-treatment decisions (NTDs); alleviation of pain and symptoms with a possible life-shortening effect; terminal sedation; and administration of lethal drugs (ie, physician-assisted dying (PAD));
- willingness to make these ELDs, given certain circumstances;
- actual decision-making.

We will also examine whether the country of residence has an effect, making it possible to evaluate also the influence of the surrounding (secular) culture.

METHODS

Design, sample and questionnaire

In six European countries, Belgium (Flanders), Denmark, Italy (Emilia-Romagna, Trento, Tuscany and Veneto), The Netherlands, Sweden and Switzerland, and in Australia, a written structured questionnaire was sent to practising physicians from 10 specialties often involved in care of the dying: anaesthesiology, general practice, geriatrics, gynaecology, internal medicine, neurology, nursing home medicine (in The Netherlands), oncology, pulmonology and surgery.2 18 For each country, a random sample of 300 physicians was selected for each specialty, or all physicians if less than 300 were active in that specialty. Questions were asked about general attitudes, intended behaviour and actual practices concerning end-of-life care, and background characteristics of the physicians. Questionnaires were sent in the second half of 2002 (after the euthanasia laws had come into effect in The Netherlands and Belgium) and were processed anonymously. More details can be found elsewhere.4 20

In the Italian version of the questionnaire, the question on religious affiliation was omitted in order not to decrease the response rate, hence Italy is not included in the analyses for this paper.

Life stance

The questionnaire asked: “What do you consider to be your religion or philosophy on life?”. Options were: “Roman Catholic”, “Protestant”, “other
Table 1  Life stance and importance of life stance in end-of-life decision-making by country

<table>
<thead>
<tr>
<th>Life stance (%)</th>
<th>Belgium</th>
<th>Denmark</th>
<th>Netherlands</th>
<th>Sweden</th>
<th>Switzerland</th>
<th>Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>64.4</td>
<td>1.1</td>
<td>28.4</td>
<td>4.5</td>
<td>30.9</td>
<td>19.1</td>
</tr>
<tr>
<td>Protestant</td>
<td>0.8</td>
<td>56.9</td>
<td>22.1</td>
<td>50.6</td>
<td>34.7</td>
<td>29.2</td>
</tr>
<tr>
<td>Orthodox</td>
<td>0.0</td>
<td>0.1</td>
<td>0.0</td>
<td>1.4</td>
<td>0.5</td>
<td>1.3</td>
</tr>
<tr>
<td>Non-religious</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific philosophy*</td>
<td>8.8</td>
<td>3.1</td>
<td>3.3</td>
<td>3.8</td>
<td>2.1</td>
<td>2.6</td>
</tr>
<tr>
<td>No specific philosophy</td>
<td>23.9</td>
<td>37.6</td>
<td>43.9</td>
<td>36.0</td>
<td>27.0</td>
<td>36.5</td>
</tr>
<tr>
<td>Religious without denomination</td>
<td>1.3</td>
<td>0.6</td>
<td>0.9</td>
<td>0.4</td>
<td>1.6</td>
<td>2.8</td>
</tr>
<tr>
<td>Self-reported importance of life stance in ELDs (% important or very important)</td>
<td>45.0</td>
<td>32.1</td>
<td>38.7</td>
<td>47.8</td>
<td>62</td>
<td>54.2</td>
</tr>
</tbody>
</table>

*Usually humanist/existentialist: 94% in Belgium, 79% in Denmark, 95% in The Netherlands, 91% in Sweden, 71% in Switzerland, 66% in Australia. The minority of physicians with other specific non-religious philosophies were mostly atheists but with Christian ethics (1.3–18.4%) and a small number of Taoists (0–4%).

ELD, end-of-life decision.

Clinical ethics

Table 1 Life stance and importance of life stance in end-of-life decision-making by country

<table>
<thead>
<tr>
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<td>0.5</td>
<td>1.3</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>3.3</td>
<td>3.8</td>
<td>2.1</td>
<td>2.6</td>
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<tr>
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<td>43.9</td>
<td>36.0</td>
<td>27.0</td>
<td>36.5</td>
</tr>
<tr>
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<td>0.6</td>
<td>0.9</td>
<td>0.4</td>
<td>1.6</td>
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ELD, end-of-life decision.

Statistical analysis

Firstly, principal component analysis was performed to reveal the underlying structure of a set of 14 statements scored on a five-point Likert scale from “totally agree” to “totally disagree”. It identified three factors of general attitudes to ELDs. Items with a component loading higher than 0.5 were retained in the factors, and standardised scores were calculated by attributing a weight equal to the factor loading to each salient variable (see appendix). Physicians with higher standardised scores on a factor thus show greater agreement with the statements that define that factor. The mean standardised factor scores (and 95% CI) of the three factors were compared between the life-stance groups.

Secondly, to describe and compare the willingness to make ELDs given certain (real life) circumstances, two hypothetical cases of a 71-year-old cancer patient with extensive brain and bone metastases were considered. For both cases, which are described in box 1, percentages were compared (Pearson χ² test) of physicians probably or certainly deciding (score 1 or 2 on a five-point Likert scale), both at the request of the patient and without any request, to:

- step up alleviation of pain/symptoms by using drugs such as opioids, taking into account the probability or certainty that this would hasten the end of the patient’s life (APS);
- administer drugs, such as benzodiazepines or barbiturates, to keep the patient in deep sedation until death, without giving hydration or nutrition (terminal sedation);
- administer drugs with the explicit intention of hastening the patient’s death (PAD).

A possible differential influence of certain circumstances on the willingness of the different life-stance groups to make the respective ELDs was also checked by comparing the differences in scores for case 1 and case 2, and for the presence or absence of an explicit patient request (tested with Kruskal–Wallis).

Thirdly, the actual decision-making in different life-stance groups was compared by examining the percentages ever having actually performed APS, terminal sedation and PAD. Pearson χ² and Fisher exact tests were used to determine the statistical significance of differences.

In all comparisons, we used only the larger life-stance groups, in view of the reliability of the results.

RESULTS

Response rates ranged from 53% in Australia to 68% in Denmark (table 1).

Life stances

Physicians separated into four large life-stance groups in all six countries (table 1): Roman Catholics (1.1% in Denmark to

Box 1: Description of the two hypothetical patients

The two patients are 71-year-old cancer patients with extensive brain and bone metastases. They have both had burdensome chemotherapy twice, and having chemotherapy once more would give a limited chance of long-standing remission (<10%).

- Case 1: The patient is drowsy or subcomatose and communication is not possible. You estimate the patient’s life expectancy (without chemotherapy) to be no more than 2 weeks. Pain can be adequately controlled, but the patient is extremely tired, short of breath and bedridden.
- Case 2: The patient is clear headed and can still communicate. You estimate the patient’s life expectancy (without chemotherapy) to be no more than 2 weeks. Pain can be adequately controlled, but the patient is extremely tired, short of breath and bedridden.
Table 2  Physicians' attitudes to end-of-life decisions by life stance

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Belgium</th>
<th>Denmark</th>
<th>Netherlands</th>
<th>Sweden</th>
<th>Switzerland</th>
<th>Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To NTD and APS</td>
<td>To use of lethal drugs</td>
<td>To preserving life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>-0.40 (-0.46 to -0.33)</td>
<td>0.21 (0.16 to 0.27)</td>
<td>-0.08 (-0.13 to -0.03)</td>
<td>0.59 (-0.66 to -0.52)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protestant</td>
<td>*</td>
<td>0.102</td>
<td>0.01</td>
<td>0.01</td>
<td>0.01</td>
<td>0.01</td>
</tr>
<tr>
<td>Non-religious (specific philosophy)</td>
<td>0.15 (0.00 to 0.30)</td>
<td>0.44 (0.15 to 0.74)</td>
<td>-0.09 (-0.43 to -0.25)</td>
<td>0.09 (0.00 to 0.18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-religious (no specific philosophy)</td>
<td>-0.03 (-0.13 to -0.07)</td>
<td>0.41 (0.33 to 0.49)</td>
<td>0.06 (-0.01 to 0.13)</td>
<td>0.05 (-0.13 to 0.07)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>p Value</td>
<td>&lt;0.001</td>
<td>0.021</td>
<td>0.002</td>
<td>0.001</td>
<td>0.001</td>
<td>0.001</td>
</tr>
</tbody>
</table>

Values are mean standardised factor score (95% CI); higher scores signify respectively more acceptance of NTD and APS, more tolerance to use of lethal drugs, stronger life-preserving attitude. The scores can be compared within and across countries.

*Only life-stance groups with more than 2% of respondents in national sample were retained in the analyses.

APS, alleviation of pain/symptoms using drugs with a possible life-shortening effect; NTD, non-treatment decision.
64.4% in Belgium); Protestants (0.8% in Belgium to 56.9% in Denmark); non-religious with a specific life philosophy such as humanism (2.1% in Switzerland to 8.8% in Belgium); non-religious with no specific philosophy on life (23.9% in Belgium to 45.9% in The Netherlands).

Those who indicated that their life stance is important in their professional attitude to end-of-life decision-making ranged from 52% of all physicians (with both theistic and non-theistic life stances) in Denmark to 62% in Switzerland.

### Life stance and general attitudes to ELDs

Three dimensions of attitudes to ELDs were distinguished by principal component analysis (appendix), for which significant differences were found between life-stance groups (table 2).

Apart from in Denmark, physicians in the religious categories were significantly less accepting of NTD and APS than physicians with non-religious life stances (especially in Belgium). In Sweden and Switzerland, Roman Catholic physicians were less accepting than Protestant physicians.

Differences between life stances were much more pronounced for attitudes to the use of lethal drugs (PAD). In all countries, but most notably in Belgium, non-religious physicians were more accepting than religious physicians. In Switzerland and Australia, Protestants were also more accepting than Catholics. Among non-religious physicians, those with a specific life philosophy tended to be more accepting than those without a specific life philosophy in Belgium (p = 0.165) and The Netherlands (p = 0.052).

Similar but inverse patterns were found for attitudes to life preservation, with particularly high scores for Swedish physicians.

### Hypothetical decision-making by life stance in different circumstances

For willingness to perform APS, no, or barely, significant differences were found between religious and non-religious

<table>
<thead>
<tr>
<th>Decision</th>
<th>Belgium</th>
<th>Denmark</th>
<th>Netherlands</th>
<th>Sweden</th>
<th>Switzerland</th>
<th>Australia</th>
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</thead>
<tbody>
<tr>
<td>Terminal sedation at patient’s request†</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>95</td>
<td>98</td>
<td>*</td>
<td>*</td>
<td>93</td>
<td>97</td>
</tr>
<tr>
<td>Protestant</td>
<td>*</td>
<td>*</td>
<td>87</td>
<td>98</td>
<td>93</td>
<td>99</td>
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<tr>
<td>Non-religious (specific philosophy)</td>
<td>98</td>
<td>99</td>
<td>95</td>
<td>100</td>
<td>95</td>
<td>100</td>
</tr>
<tr>
<td>Non-religious (no specific philosophy)</td>
<td>97</td>
<td>98</td>
<td>87</td>
<td>100</td>
<td>93</td>
<td>98</td>
</tr>
<tr>
<td>p Value</td>
<td>0.134</td>
<td>0.670</td>
<td>0.313</td>
<td>0.055</td>
<td>0.916</td>
<td>0.218</td>
</tr>
<tr>
<td>Terminal sedation on own initiative</td>
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<tr>
<td>Roman Catholic</td>
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<td>79</td>
<td>*</td>
<td>*</td>
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<td>45</td>
</tr>
<tr>
<td>Protestant</td>
<td>*</td>
<td>*</td>
<td>82</td>
<td>78</td>
<td>70</td>
<td>49</td>
</tr>
<tr>
<td>Non-religious (specific philosophy)</td>
<td>87</td>
<td>85</td>
<td>49</td>
<td>54</td>
<td>75</td>
<td>80</td>
</tr>
<tr>
<td>Non-religious (no specific philosophy)</td>
<td>81</td>
<td>76</td>
<td>78</td>
<td>77</td>
<td>67</td>
<td>47</td>
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<tr>
<td>p Value</td>
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<tr>
<td>PAD at patient’s request†</td>
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</tr>
<tr>
<td>Roman Catholic</td>
<td>81</td>
<td>78</td>
<td>*</td>
<td>*</td>
<td>74</td>
<td>62</td>
</tr>
<tr>
<td>Protestant</td>
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<td>*</td>
<td>52</td>
<td>47</td>
<td>71</td>
<td>70</td>
</tr>
<tr>
<td>Non-religious (specific philosophy)</td>
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<td>85</td>
<td>49</td>
<td>54</td>
<td>75</td>
<td>80</td>
</tr>
<tr>
<td>Non-religious (no specific philosophy)</td>
<td>84</td>
<td>80</td>
<td>56</td>
<td>52</td>
<td>71</td>
<td>66</td>
</tr>
<tr>
<td>p Value</td>
<td>0.121</td>
<td>0.011</td>
<td>0.297</td>
<td>0.159</td>
<td>0.823</td>
<td>0.048</td>
</tr>
</tbody>
</table>

Values are the percentages probably or certainly agreeing to make a given end-of-life decision; p values are from Pearson χ² test.

Case 1: the patient is drowsy or subcomatose and communication is not possible. You estimate the patient’s life expectancy (without chemotherapy) to be no more than 2 weeks. Pain can be adequately controlled, but the patient is extremely tired, short of breath and bedridden.

Case 2: the patient is clear headed and can still communicate. You estimate the patient’s life expectancy (without chemotherapy) to be no more than 2 weeks. The patient had pain that is difficult to control despite the use of high doses of analgesics.

*Only life-stance groups with more than 2% of respondents in national sample were retained in the analyses

†For case 1 (communication not possible) “at patient request” was defined as a request stated in an advanced directive.

APS, alleviation of pain/symptoms using drugs with a possible life-shortening effect; PAD, physician-assisted death.
The effect was comparable for terminal sedation (Belgium and Switzerland) and highest among non-religious Belgian physicians with a specific life philosophy for case 1 (41.4%). Differences between life stances in The Netherlands, Sweden and Switzerland, had performed a PAD more often. In Sweden, terminal sedation had been performed significantly more often by non-religious physicians with a specific life philosophy in Sweden and Belgium; however, it was also a relatively common practice among religious physicians, particularly Catholics (from 25.9% in Switzerland to 40.4% in The Netherlands).

Life stance and actual decision-making

Differences in actual decision-making about APS and terminal sedation were small between life stances (table 4). APS had been performed more often by non-religious than by religious physicians and by Protestants than by Catholics in Sweden and in Switzerland. Terminal sedation had been performed significantly more often by non-religious physicians with a specific life philosophy in Sweden and Belgium; however, it was also a relatively common practice among religious physicians, particularly Catholics (from 25.9% in Switzerland to 40.4% in The Netherlands).

For PAD, differences were more marked. Non-religious physicians, particularly those with a specific philosophy such as humanism (in Belgium, Denmark, The Netherlands, Switzerland), had performed a PAD more often. In Sweden, the proportion ever having done so was very low, with no Roman Catholic or non-religious physician without a specific life philosophy ever having performed a PAD and only 2.5% of the non-religious physicians with a specific life philosophy having done so. In comparison, in The Netherlands, 15.7% of Catholic and 20.4% of Protestant physicians had ever performed a PAD.

DISCUSSION

Our findings show that physicians' life stances may result in different ELD-making, as suggested by Wenger and Carmel. Whereas moderate differences were found between life stances with respect to attitudes to, and actual making of non-treatment decisions, as well as of stepping up alleviation of pain/symptoms with a possible life-shortening effect, or terminal sedation, these differences were very large with respect to the use of drugs with the explicit intention of hastening the patient's death (ie, PAD). Although life stance does indeed seem...
to influence both attitudes and actual behaviour, there seems to be an even larger effect of the country of residence, possibly indicating that the (country-specific) surrounding culture is a more relevant determinant of behaviour than (theoretical) differences in the teachings of various life stances.

Our study had a large-scale, cross-national design to allow investigation of the relationship between life stance and ELDs, and also to take account of variation in religious cultural backgrounds (eg, history and patterns of secularisation). A major strength is that the study describes attitudes, as well as intended and actual behaviour. The study had certain limitations. Firstly, the life stance variable was solely based on self-declaration. The question also used a general category of “Protestant”, which did not allow discrimination of patent differences with respect to ELDs between liberal, moderate and conservative Protestant churches. Secondly, to maintain an acceptable response rate, the life-stance question was omitted in Italy. Therefore we could not include this country with a strong Roman Catholic cultural background.

Differences identified between physicians with different life stances in attitudes, hypothetical behaviour and actual decision-making can be discussed in the framework of viewpoints and teachings of different life stances on NTDs, possibly life-shortening pain and symptom alleviation, terminal sedation, and PAD.

The finding of generally small differences between Christian (Protestant and Roman Catholic) life stances and non-religious life stances in the acceptance, as well as the actual practice, of NTDs and possibly life-shortening escalation of pain/symptom- alleviating drugs can be seen in accordance with these religions’ acceptance of the human condition and inevitability of death, or rather the psychological difference between “doing” and “allowing”. The fact that the use of opioids rarely actually shortens life may be an additional explanation for the relatively positive attitude of, and frequent practice by, both religious and non-religious physicians.

The minor differences between religious and non-religious physicians in their approval of terminal sedation may be explained in a similar way. However, sedation has a particular position in Christian doctrine, as the use of drugs is regarded as wrong (particularly in Catholicism and in conservative Protestantism), the individual is neither the steward of God’s sacred gift of life nor the arbiter of his own death, but a steward of God’s sacred gift of life. Therefore, the Roman Catholic central authority uniformly declares euthanasia to be immoral and equivalent to killing (eg, in the official declaration on euthanasia). Our results show that Catholics were indeed generally much less inclined to accept (or to perform) PAD (including euthanasia and physician-assisted suicide) than non-Catholic physicians.

However, notwithstanding the Roman Catholic Church’s blanket rejection of euthanasia, relatively high percentages of Catholics seemed to be open to the practice of euthanasia: in The Netherlands, up to 47.8% of Roman Catholics said that they would consider performing euthanasia (ie, PAD at the patient’s request) on a hypothetical patient, and a non-negligible percentage of Roman Catholics admitted to having performed PAD (2.9% in Australia, 3.4% in Switzerland, 6.1% in Belgium, and 15.7% in The Netherlands). Moreover, physicians with a life stance seemingly connected with an absolutist moral orientation are sensitive to the peculiarity of circumstances. Our data show that a considerably higher proportion of religious physicians are willing to administer lethal drugs at the patients’ request than in the absence of any request. Religious physicians are thus to some extent willing to comply with patients’ explicit requests.

Although relatively large differences were found depending on the physician’s life stance, much larger differences were found depending on the country of residence. For PAD, a high acceptance and a high frequency of physicians ever performing these actions was found in Belgium and The Netherlands, but in Sweden it was very low. The circumstances of the decision-making, such as the presence of a patient request, also appeared to play a larger role in some countries than in others (eg, it appeared to be a more important factor in the acceptability of PAD for Dutch physicians than for Belgian physicians). Moreover, the country of residence was also related to the way in which physicians with different life stances framed their opposition. Belgian and Dutch Catholics were relatively accepting of the use of lethal drugs, and were even more accepting than non-religious physicians from the other countries studied (most notably Sweden). This is also translated into actual behaviour: Dutch Catholic physicians more often performed PAD than non-religious ones in any other country studied. Being a Roman Catholic in countries such as Belgium and The Netherlands implies less commitment to the Vatican’s rejection of euthanasia than in the other countries. Moreover, in Sweden and The Netherlands, Roman Catholics were more tolerant of physician-assisted suicide than Protestants, although in other countries the converse was true.

These differences can partially be explained by the surrounding secular culture (and the strength of the voice of the religious authorities). Physicians in a society that values individual choice and self-determination with regard to ways of life are more likely to also value individual choice and self-determination with regard to (ways of) death, even if they are religious. It is also possible, however, that other factors contribute to the tolerance of physicians to PAD (eg, low or high participation of patients in decision-making). It can be safely hypothesised that the actual or imminent achievement of legal status, as is the case in The Netherlands, Switzerland and Belgium, is a major cultural factor determining attitudes and practice.
GENERAL CONCLUSIONS
We have shown that the teachings of religious bodies indeed influence end-of-life decision-making, but are certainly not bluntly accepted by physicians. The effect of doctrinal teachings is somewhat clearer on general attitudes to ELDs and the actual stances of the followers of those doctrines in realistic situations. It can perhaps be explained by the fact that most people embrace (theistic) belief not in strict metaphysical terms, but in non-imperative ways, allowing adaptation to particular situations—for instance, to the needs and wishes of the dying and to considerations of humaneness.

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Competing interests: None.

REFERENCES

APPENDIX
Principal component analysis: retained items and their component loadings

<table>
<thead>
<tr>
<th>Item</th>
<th>Attitude to NTD &amp; APS</th>
<th>Attitude to using lethal drugs</th>
<th>Life preserving attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Physicians should comply with a patient’s request to withhold or withdraw life-sustaining treatment</td>
<td>0.79</td>
<td>–</td>
</tr>
<tr>
<td>2</td>
<td>If necessary, a terminally ill patient should receive drugs to relieve pain and suffering, even if these drugs may hasten the end of the patient’s life</td>
<td>0.65</td>
<td>–</td>
</tr>
<tr>
<td>3</td>
<td>A person should have the right to decide whether or not to hasten the end of his or her life</td>
<td>–</td>
<td>0.70</td>
</tr>
<tr>
<td>4</td>
<td>In all circumstances physicians should aim to preserve the lives of their patients, even if patients ask for the hastening of the end of their lives</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>5</td>
<td>The use of drugs in lethal doses on the explicit request of the patient is acceptable for patients with a terminal illness with extreme uncontrollable pain or other distress</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>6</td>
<td>If a terminally ill patient is suffering unbearably and is not capable of making decisions, the physician should be allowed to administer drugs in lethal doses</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>7</td>
<td>Permitting the use of drugs in lethal doses on the explicit request of the patient will harm the relationship between patients and physicians</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>8</td>
<td>Clear wishes on withholding or withdrawing life-sustaining treatment of an incompetent patient as expressed in an advance directive must always be respected, even if this could hasten the end of the patient’s life</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

Note: only items with component loading higher than 0.50 were retained in the factors.
Influence of physicians' life stances on attitudes to end-of-life decisions and actual end-of-life decision-making in six countries

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